Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Respondent Name
ACE AMERICAN INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-08-4781-01

MFDR Date Received
March 27, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the fair and reasonable reimbursement amount for this hospital outpatient admission should be commensurate with the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as this admission for those admissions involving the same Principal Diagnosis Code and Principal Procedure Code."

Amount in Dispute: $22,434.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to the request for medical fee dispute resolution. However, the respondent did submit an *Objection & Response to Requestor's Amended Position Statement*, which concludes in summary that: "the bottom line is that to this date no evidence of the eight characteristics of 'fair and reasonable' has been provided by Requestor. Thus, Requestor has provided no viable rationale to support a claim for additional reimbursement. . . . Neither the bare use of historical payment data limited to workers' compensation cases, nor use of the 2008 Outpatient Hospital Fee Guideline comply with statutory and regulatory requirements for determining whether the amount claimed by a healthcare provider is 'fair and reasonable.'"

Response Submitted by: Downs Stanford, PC, 115 Wild Basin Rd., Suite 207, Austin, Texas 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 17, 2007 to September 18, 2007	Outpatient Services	$22,434.98	$4,732.93

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers' compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
5. By letter dated August 2, 2011, the attorney for the requestor provided *REQUESTOR'S AMENDED POSITION STATEMENT (RENAISSANCE HOSPITAL – DALLAS)* that specified, in pertinent parts, an "Additional Reimbursement Amount Owed" of $4,732.93 and an "alternative" "Additional Reimbursement Amount Owed" of $8,952.86. The Division notes that the amount in dispute of $22,434.98 specified above is the original amount in dispute as indicated in the requestor's *TABLE OF DISPUTED SERVICES* submitted prior to the *REQUESTOR'S AMENDED POSITION STATEMENT*.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service. This change to be effective 4/1/2008: Payer deems the information submitted does not support this level of service.
   - 850-243 – CV: THE RECOMMENDED ALLOWANCE REFLECTS A FAIR REASONABLE AND CONSISTENT METHODOLOGY OR REIMBURSEMENT PURSUANT TO THE CRITERIA SET FORTH IN SECTION 413.011(D) OF THE TEXAS WROKERS' COMPENSATION ACT.
     - M-NO MAR. $0.00
     - M-NO MAR. $1,100.00
   - 900-030 – CV: THIS CHARGE WAS REVIEWED THROUGH THE CLINICAL VALIDATION PROGRAM
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 855-002 – RECOMMENDED ALLOWANCE IS IN ACCORDANCE WITH WORKERS COMPENSATION MEDICAL FEE SCHEDULE GUIDELINES. $1,006.50
   - 647-002 – REIMBURSEMENT HAS BEEN CALCULATED BASED ON A PERCENTAGE OF THE CHARGES.
   - 45 – [No description of this code was found with the submitted materials.]

Findings

1. Review of the submitted explanations of benefits found that disputed services were reduced or denied by the insurance carrier using reason code 45. No description or explanation for the use of this reason code was found in the submitted materials. This reason code is usually related to contractual fee adjustments. No documentation was found to support that the disputed services were subject to a contractual fee agreement between the parties to this dispute. Nevertheless, on June 9, 2011, the Division requested the respondent to provide a copy of the referenced contract(s) between the alleged network and the requestor, as well as documentation to support notice to the hospital, pursuant to former 28 Texas Administrative Code §133.307(e)(1), effective December 31, 2006, 31 *Texas Register* 10314, which states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available." Attorney Nicholas Canaday, III of the law firm Downs Stanford, PC, responded on behalf of the insurance carrier by letter dated April 13, 2012, which stated that "Respondent did not reduce this medical bill pursuant to a network. Instead, the bill was reduced to a fair and reasonable amount. No PPO contract was utilized to reduce the medical bill in dispute in this matter." Review of the submitted information finds that the disputed services are not subject to a contract between the parties to this dispute. The above payment reduction reason code is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. The respondent's supplemental response objects to the requestor's amended position statement, asserting that "This new submission violates most of the governing principles of medical fee dispute resolution and is flatly filed out-of-time." In support of which, the respondent asserts that "Chapter 133, Subchapter C Rules required the Requestor, upon reconsideration, to respond with documentation not submitted with the original medical bill to support the Requestor's position . . . Requestor, then and now, does not comply with this Rule." No documentation was found to support the respondent's assertion that the requestor is limited to arguing at Medical Fee Dispute Resolution only those positions presented to the carrier during the bill submission and reconsideration process. The Division notes that while 28 Texas Administrative Code §133.307(d)(2)(B), 31 *Texas Register* 10314, prohibits the *respondent* from raising new denial reasons or defenses that were not presented to the requestor prior to the filing of the request for dispute resolution, no similar bar is set against the requestor. The respondent further states that "Now, years later, and without any reference to its total charges billed, its original 'fair and reasonable' methodology, or its original reimbursement demands, Renaissance advances a 'new' definition of a fair and reasonable reimbursement. This is both improper and untimely . . . Bottom Line: There is no rule which allows Renaissance to abandon its original position in its entirety and then present a complete change of position that was submitted neither to the Respondent for consideration and reconsideration, nor to the Medical Review Division in its DWC-60." No documentation was found to support the respondent's assertion that the submitted information was untimely. While Division rules set timely filing limits for the initial request and response, there is no time limitation as to the submission of supplemental information. The Division notes that the medical fee dispute process has allowed, for many years, both parties to a dispute to submit additional information until the assigned medical dispute resolution officer begins adjudication of the dispute. The Division has previously stated in the adoption preamble to 28 Texas Administrative Code §133.307, 31 *Texas Register* 10314, that "The Division must be able to obtain relevant and necessary information in order to determine fundamental issues regarding fee disputes." The supplemental filings in the present dispute are directly related to the "fair and reasonable" fee reimbursement methodology at issue. Moreover, the requestor noted in its amended position statement that "it is necessary and proper to update the file because the Requestor has a new attorney of record after the health care provider was placed in bankruptcy." The respondent has had notice and opportunity to respond to all of the requestor's filings in this dispute, and has availed itself of the opportunity to do so. Therefore the submitted information will be considered in this review.
3. This dispute relates to services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's amended position statement asserts that "the fair and reasonable reimbursement amount for this hospital outpatient admission should at least be commensurate with the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as this admission for those admissions involving the same Principal Diagnosis Code and Principal Procedure Code."
   - In support of the requestor's methodology the requestor states that "Ordering additional reimbursement based on the average amount paid system-wide in Texas achieves effective medical cost control because it prevents overpayment... creates an expectation of fair reimbursement; and . . . encourages health care providers to continue to offer quality medical care to injured employees . . . Ordering additional reimbursement for at least the average amount paid for a hospital outpatient admission during the same year of service and involving the same Principal Diagnosis Code and Principal Procedure Code ensures that similar procedures provided in similar circumstances receive similar reimbursement . . . The average amount paid for similar admissions as put forward by the Requestor is based on a study of data maintained by the Division."

- The Division notes that it has utilized similar data to determine "fair and reasonable" fee guidelines. See, for example, the adoption preamble to the *Hospital Facility Fee Guideline—Outpatient* at 28 Texas Administrative Code §134.403, 33 *Texas Register* 400-407, which specified, in pertinent parts, that "In maintaining a medical billing database, the Division requires carriers to submit billing and reimbursement information to the Division on a regular basis . . . The Division provided Milliman with the 837 data set for CY 2005, which included information on approximately 12,000 inpatient billing lines and 166,000 hospital outpatient billing lines . . . Milliman estimated that CY 2005 Texas workers' compensation outpatient facility reimbursement represented approximately 186 percent of Medicare allowable levels for outpatient services . . . The Division considered the issues of medical cost containment as prescribed by Labor Code §413.011 . . . Research conducted by the Workers' Compensation Research Institute concludes that . . . hospital outpatient payments per claim in Texas were lower than the 13-state median studied . . . Based on all of these factors . . . The Division adopts PAFs of 200 percent and 130 percent of Medicare reimbursement for use in determining Texas workers' compensation outpatient facility service reimbursement."
- The requestor submitted documentation to support the state-wide, annual, average reimbursement in Texas for the principal diagnosis code and principal procedure code of the disputed services during the year that the services were rendered.
- The requestor has explained and supported that the requested reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is supported. Thorough review of the submitted documentation finds that the requestor has discussed, demonstrated, and justified that the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as the disputed admission for those admissions involving the same principal diagnosis code and principal procedure code is a fair and reasonable rate of reimbursement for the services in dispute.

6. In the alternative, the requestor proposes that "it is justifiable to order additional reimbursement under the Hospital Facility Fee Guidelines – Outpatient because the Division's new fee guidelines, while not in effect at that time, are presumptively fair and reasonable reimbursement under the law and data from the Medicare Outpatient Prospective Payment System for this date of service is available for calculating the amount due." Review of the submitted documentation finds that:
   - In support of the alternative requested reimbursement methodology the requestor states that "The data necessary to calculate the Maximum Allowable Reimbursement is readily available from the Medicare Outpatient Prospective Payment System. Therefore, the new fee guidelines as adopted in 28 TEX. ADMIN. CODE § 134.403 provide a presumptive measure for the fair and reasonable reimbursement amount."
   - The requestor did not submit documentation to support the Medicare payment calculation for the services in dispute.
   - The fee guidelines as adopted in 28 Texas Administrative Code §134.403 were not in effect during the time period when the disputed services were rendered.
   - The Division disagrees that the fee guidelines as set forth in §134.403 are "presumptively fair and reasonable reimbursement under the law" for dates of service prior to the date the rule became effective. No documentation was found to support such a presumption under law.
   - While the Division has previously found that Medicare patients are of an equivalent standard of living to workers' compensation patients (22 *Texas Register* 6284), Texas Labor Code §413.011(b) requires that "In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d) . . . This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services."
   - The requestor did not discuss or present documentation to support how applying the proposed payment adjustment factors as adopted in 28 Texas Administrative Code §134.403, effective for dates of service on or after March 1st, 2008, would provide fair and reasonable reimbursement for the disputed services during the time period that treatment was rendered to the injured worker.
   - The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the alternative requested reimbursement.
   - The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for an alternative reimbursement amount calculated based on the formulas in the Hospital Facility Fee Guideline – Outpatient, as set forth in §134.403, is not supported. The requestor has not demonstrated or presented sufficient documentation to support that the alternative additional amount requested would provide a fair and reasonable rate of reimbursement for the services in dispute.

7. The respondent's supplemental response asserts that "A carrier/self-insured has no burden of proof in this proceeding." However, in the preamble to the adoption of 28 Texas Administrative Code §133.307, 31 *Texas Register* 10314, the Division addressed a commenter that opposed §133.307(d)(2)(A)(iv)(V) expressing a concern that the rule shifts the burden of proving fair and reasonable reimbursement from the health care provider to the carrier. The Division responded that "The Division disagrees this provision places the burden of proving fair and reasonable reimbursement on the carrier only. Section 133.307 requires the provider and carrier to submit documentation that discusses, demonstrates, and justifies that the payment amount being sought by the provider and reimbursed by the carrier is a fair and reasonable rate. Further, the requirement that carriers provide documentation supporting a fair and reasonable reimbursement is consistent with the requirements of 28 TAC §134.1 and Labor Code §413.011." In the present dispute, the requestor has discussed, demonstrated and justified that the amount being sought is a fair and reasonable rate. This dispute involves health care for which the Division has not established a MAR; therefore, per §133.307(d)(2)(A)(iv)(V) the respondent is similarly required to discuss, demonstrate and justify that the amount paid is a fair and reasonable rate of reimbursement for the services in dispute.
8. 28 Texas Administrative Code §133.307(d)(2)(A)(iv)(V), effective December 31, 2006, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, requires the respondent to provide "documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable reimbursement in accordance with Labor Code §413.011 and §134.1 of this title if the dispute involves health care for which the Division has not established a MAR, as applicable." Review of the submitted documentation finds that:
   - The respondent has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The respondent did not discuss or explain how the amount paid represents a fair and reasonable reimbursement for the services in dispute.
   - The respondent did not submit documentation to support that the amount paid is a fair and reasonable rate of reimbursement for the disputed services.
   - Review of the explanation of benefits with review date 12/11/2007 finds that the respondent reduced payment on disputed services based on reason code (647-002) – "REIMBURSEMENT HAS BEEN CALCULATED BASED ON A PERCENTAGE OF THE CHARGES."
   - The Division has previously found that a reimbursement methodology based on payment of a percentage of billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

     > A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.

     Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the amount paid is a fair and reasonable reimbursement for the services in dispute.
   - The respondent submitted page 68795 from the *Federal Register* Volume 70, Number 217, November 10, 2005, relating to the Centers for Medicare and Medicaid Services' Medicare Program and changes to the Hospital Outpatient Prospective Payment System calendar year 2006 payment rates. Respondent has highlighted the payment rates for certain of the procedure codes for the services in dispute as follows:

29873	$1,670.39
29876	$1,670.39
29881	$1,670.39
29888	$2,630.83

   - 28 Texas Administrative Code §133.307(d)(2)(A)(iv)(IV) requires the respondent to discuss "how the submitted documentation supports the respondent's position for each disputed fee issue." Review of the documentation submitted by the respondent finds that the respondent has not discussed how the above information from the *Federal Register* supports the respondent's position. The Division concludes that the respondent has not met the requirements of §133.307(d)(2)(A)(iv)(IV).
   - Further, the sum of the above rates is $7,642.00. The respondent has paid $2,106.50. The Division notes that, based on the documentation submitted by the respondent, the insurance carrier's payment for the disputed services falls short of the listed rates paid under the Medicare Program. The respondent did not explain how the above data supports the amount paid by the insurance carrier, or the respondent's position that additional reimbursement is not due. However, in the absence of such explanation by the respondent,

a plain reading of the respondent's own data supports, rather, that the amount paid by the insurance carrier was *not* a fair and reasonable reimbursement for the services in dispute.

- As stated above, while the Division has previously found that Medicare patients are of an equivalent standard of living to workers' compensation patients (22 *Texas Register* 6284), Texas Labor Code §413.011(b) requires that "In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d) . . . This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services."
- No discussion or documentation was presented by the requestor to support a conversion factor or other payment adjustment factor to be applied to the Medicare payment rates submitted by the respondent.
- The respondent did not explain how the amount paid satisfies the requirements of §134.1.

The respondent's position is not supported. Thorough review of the submitted documentation finds that the respondent has not demonstrated or justified that the amount paid is a fair and reasonable rate of reimbursement for the services in dispute. The Division concludes that the respondent has not met the requirements of 28 Texas Administrative Code §133.307(d)(2)(A)(iv)(V).

9. The Division finds that the requestor has met the burden of proof required to establish by a preponderance of the evidence that additional reimbursement is due. The documentation submitted in support of the fair and reasonable methodology proposed by the requestor based on the average amount paid by all insurance carriers in the same year for admissions involving the same principal diagnosis code and principal procedure code as the services in dispute is the best evidence presented for consideration in this dispute of an amount that will achieve a fair and reasonable reimbursement for the disputed services. Reimbursement will therefore be calculated as follows. Review of the medical bill finds that the principal diagnosis code for the disputed services is 717.83. The principal procedure code is 814.5. The requestor submitted documentation to support that the average, state-wide reimbursement for this diagnosis code and procedure code performed in 2007 was $6,839.43. This amount less the amount previously paid by the respondent of $2,106.50 is $4,732.93. This amount is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the requestor has established by a preponderance of the evidence that additional reimbursement is due. As a result, the amount ordered is $4,732.93.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,732.93 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	November 1, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.